D H E C

PROMOTE PROTECT PROSPER

SC ADAP INSURANCE UPDATE

Please fill out and return to:
Patti Sullivan, STD/HIV
PO Box 101106
Columbia, SC 29211

Phone Numbers:
(803) 898-0214
(877) 606-8498

FAILURE TO RETURN THIS FORM MAY RESULT IN A DELAY IN PROCESSING YOUR REIMBURSEMENT

(please print clearly)

Name: _____
Last First Full Middle Name

Home Address: _____ City: _____ State: _____

Zip: _____ County: _____ Phone (H): (____) _____ (W): (____) _____

Mailing Address: _____ City: _____ Zip: _____

Birth Date: Mon ____ Day ____ Year ____ Sex: ____ Weight: ____ Social Security #: ____/____/____

Ethnicity (check one): ☐ Hispanic/Latino(a) ☐ Non-Hispanic /Latino(a) **Race (check all that apply):** ☐ White ☐ Black

☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaskan Native ☐ Unknown ☐ Other _____

SOCIAL AND FINANCIAL DATA

Applicant and Other Members in Household	Relationship To Applicant	Sex	DOB	Place of Employment or Source of Other Income	Estimated **Annual** Gross Income
Your Information	Already listed above				

ASSETS (list only if applying for Insurance Continuation):

Cash/Savings $ _____ Stocks/Bonds $ _____

Severance Pay $ _____ Mutual Funds $ _____

Current Physician: _____ **Current Case Manager:** _____

Current Medications: _____ _____ _____

_____ _____ _____ _____

Please note: Funds for this program come from Federal programs and are for low-income persons. This program should be the payor of last resort. Persons with Medicaid coverage or Veteran's Affairs Benefits cannot qualify for this program. Persons with insurance coverage may qualify for reimbursement of copay/deductible charges.

Are you currently approved for Medicaid? **Yes** ____ **No** ____
Do you currently have an application pending for Medicaid or Medicaid Waiver benefits? **Yes** ____ **No** ____
Do you have insurance coverage for prescriptions? **Yes** ____ **No** ____

If yes, Company Name _____ Policy Number _____ % of Coverage _____

CERTIFICATION/CONSENT: I certify that the information provided in this application is true and correct to the best of my knowledge. I give permission to ADAP to verify this information, either through written documentation or electronic files. I agree to notify ADAP of any changes to my income or Medicaid/insurance status within 30 days. I will inform ADAP if my address changes or if I choose not to participate in the program. I understand that refusal to use third party resources and/or other requirements are reasons for closure to further program sponsorship. **I also understand the importance of taking medications as prescribed and that failure to do so may result in my being automatically dropped from the program after 90 days.** ***By my signature, I authorize the release of information pertaining to my participation in ADAP to other pharmaceutical companies or pharmacies, as needed. I further authorize the release of information pertaining to my participation in ADAP for the purpose of payment and to organization(s) associated with the current physician and current case manager indicated above.***

Applicant's Signature _____ **Date** _____

Dear ADAP Insurance Patient:

Please fill out the Update/Recertification form on the reverse page and return it to me at the address indicated as soon as possible.

ALL SECTIONS MUST BE COMPLETED, *but fill out the "Assets" section only if you're enrolled in the Continuation program* where ADAP pays for or reimburses your insurance premium.

Failure to return this form may result in a delay in processing your reimbursement request.

You do not need to call to verify that I have received your form nor will you receive a follow-up call from me unless I have a question. If your form is not filled out completely, it will be returned to you.

Please call me at (803) 898-0214 or toll free at (877) 606-8498 if you have any questions.

Patti Sullivan
Insurance Coordinator